P10439.5

REGIONAL TREATMENT CENTER NEGOTIATIONS

PROPOSAL OF DEPARTMENT OF HUMAN SERVICES

JULY 28, 1988

INTRODUCTION

To further the negotiations concerning the regional treatment centers, the Department of Human Services offers this proposal. It attempts to clarify the role for the regional centers over the next 10 or more years, and presents a plan to complete the process of moving persons with developmental disabilities into small community-based homes while retaining a role for the State in the delivery of services to that group.

The proposal is based on projected need for the services offered, with due regard for the role the State has played historically in the delivery of services.

The proposal must be placed in the larger context of the trend to serve people close to home and the increased capacity of the counties and other service providers to coordinate and deliver services.

The proposal rests on the premise that regional treatment centers should not be permanent homes, and therefore should provide specialized services designed to stabilize persons and promote their return to a small, community-based home, with their family or in another placement.

This proposal is the starting point. It should be reviewed with the understanding that it will change and become more detailed as the areas of agreement evolve. Some cost projections were made during its development, but others are dependent on further elaboration of detail. Thus, we may start down roads that look promising and have to retrace steps. With that caveat, the Department has begun to make choices and develop its view of the future for the State's delivery of services. It is a proposal; we are consulting with you in order to reach a decision.

Carpus	Recommendation	Service Options	Alternative Uses	Critical Issues
Fergus Falls	.service to mentally ill and chemically dependent on re-capitalized campus			.need for new physical plant .location
	.service to developmentally disabled through SOCS			.capital, feasible management structure
	.day habilitation and training services			
		.regional support services		
Moose Lake	.service to mentally ill and chemically dependent on re-capitalized campus .service to developmentally disabled through SOCS			.need for new physical plant .location .capital, feasible management structure
	.day habilitation and training services			
		.regional support services	.correctional system	
Oak Terrace	.relocate capacity to serve elderly, some in affiliation with new metropolitan psychiatric hospital			.location, capital

BACKGROUND

The State has the responsibility to protect the rights of patients served in its regional centers and nursing homes as set forth in Minnesota Statute Section 253B.03, which includes the right to receive proper care and treatment best adapted to helping the person back to the community.

Over the years, the regional treatment centers and nursing homes have provided necessary services which have benefited many people throughout the State.

The State has provided treatment in ways which have varied over the years as professional standards have shifted.

The State has not consistently devoted the resources to the regional treatment centers and nursing homes which have been necessary to assure active treatment suited to each individual's needs. This is reflected in several ways:

- design and current condition of physical plant;
- number of staff;
- staff training;
- insufficient supplies and equipment.

Over the years, the trend in service delivery has been to serve people as near to their home community as possible in order to:

- facilitate family involvement during placement;
- ease the client's transition into and out of care;
- encourage development of services;
- increase the likelihood that skills acquired during treatment have application after discharge.

In response to this, many local alternatives to the regional treatment centers have developed, including:

- alternative housing and day programs for the developmentally disabled;
- community mental health centers;
- residential treatment programs;
- outpatient treatment programs;
- home-based care services;
- community support programs;
- public schooling for children with handicaps.

Thus, the array of services offered in communities has expanded, and that expansion is likely to continue because of:

- desire to offer choices to the persons served and their families;
- demand for home and community-based services;
- shifts in funding which has encouraged that development.

Simultaneously, the results of numerous studies indicate that:

> Long-term residential care in large congregate settings reinforces patterns which impede rather than facilitate movement back to the community.
>
> Small residences located in neighborhoods can be designed and staffed to provide stable, safe housing and treatment.
>
> Integration of small homes for disabled people into neighborhoods increases the opportunity for interaction, provides appropriate models for persons with handicaps, increases the opportunity to develop skills which can be generalized outside an institution, and reduces the sense of isolation for both clients and staff.

Although the population at regional treatment centers has gone down, the cost of providing services has continued to go up. A large part of the increase is attributable to enhanced staffing to insure that treatment is provided which is best-9uited to stabilizing the person, developing an individualized plan of care and facilitating the person's move back to the community. For persons with mental illness or developmental disabilities, this increased level of treatment is required by DHS rules governing services, by the conditions established for federal funding of treatment programs, and encouraged by the standards of outside accreditation groups and pressure from clients and their advocates. "Active treatment", which means a full day of activity built upon an assessment of the individual and structured to facilitate discharge from an institution, is a prerequisite to federal funding.

For the elderly and persons with chemical dependency and developmental disabilities, the State currently requires pre-admission screening or assessment to establish the appropriate type of service and level of intensity needed. This requirement will apply to persons with mental illness in 1991. The purpose of screening is to insure that persons admitted to the regional treatment centers actually require the level of care the centers provide and that they cannot be served by an available community placement.

The State has an obligation to set minimum standards for care in programs it licenses and to monitor compliance with those standards. This is the heart of quality assurance since the purpose of setting minimum standards is to assure that the proper conditions exist which will encourage success.

The State strives to exceed minimum standards in the programs it operates and to attain contemporary professional standards for staffing levels and for quality of program, staffing, and physical environment.

The State plays an important role in monitoring service. As service delivery becomes more dispersed, new approaches to monitoring will be needed.

The State also has a role to play in providing technical assistance and training so that the quality of services is improved throughout its regions.

CHEMICAL DEPENDENCY

I. INTRODUCTION

In 1987, DHS Rule 25 took effect which set criteria to be used by counties in determining the appropriate level of care for public assistance clients seeking treatment.

On January 1, 1988, the Consolidated Chemical Dependency Treatment Fund (CCDTF) took effect with three significant results for the regional treatment centers.

1. Regional treatment centers' CD units were placed in competition with all other CD programs.

2. A revolving fund was established for the operation of the regional treatment centers' CD programs, replacing a direct appropriation.

3. Funds from several sources were consolidated so that the counties could spend the money on services suited to an individual's needs, rather than allowing the availability of funds to dictate services. Historically, placing people at the regional centers cost counties less than placements in other programs.

The effect of Rule 25 and the Consolidated Chemical Dependency Treatment Fund is that admissions to regional treatment centers for CD services have dropped.

Based on information available to DHS at this time, the CCDTF is working as envisioned by the statute. The counties are using the money to serve more people and placing people appropriately. Further evaluation will be done to insure that eligible persons are not denied needed services, including in-patient treatment, because of a shortage of funds.

The Department is committed to operating chemical dependency services using a competitive model. It will continue to provide in-patient treatment for CD in the regional treatment centers so long as it can compete for business. There are certain types of persons not being well-served by other providers and it is estimated that demand for primary and extended residential care provided by the regional treatment centers will stabilize at the current level.

The criteria for admission to chemical dependency services are set forth in Rule 25:

Inpatient:

Court commitment under Chapter 253B; or

"Chemical dependency", - pattern of pathological use accompanied by the physical manifestations of increased tolerance to the chemical or chemicals being used or withdrawal syndrome following cessation of chemical use, coupled with inability to abstain from chemical use outside a residential facility that controls access; or

"Chemical abuse" - inappropriate or harmful use of chemicals and an arrest, loss of job or education, or deterioration of family relationships because of chemical use and a psychiatric diagnosis or medical complication requiring regular nursing care.

Outpatient:

"Chemical abuse" - as defined above, but without the further requirement of a psychiatric diagnosis or need for nursing.

II. SERVICES OFFERED

A. Primary and Extended Residential Care:

Services will focus on primary and extended residential care, and will specialize as needed. DHS anticipates it will be competitive in services for persons who are chemically dependent and are:

1. American Indians
2. Women
3. Hearing impaired
4. Referred by criminal justice system
5. Committed by a court pursuant to Minn. Stat. Chapter 253B
6. Mentally Ill
7. Addicted to opiates

There are few programs in the community to serve persons who are both mentally ill and chemically dependent. The regional treatment centers are well-suited to developing service for such people.

B. Other Services:

To the extent that the regional treatment centers' CD programs can compete within their region, they may also offer:

1. Follow-up care to persons discharged from regional treatment center inpatient programs;

2. Out-patient programs on campus;

3. Purchased services or shared services:

a. CD counseling for persons in correctional facilities

NOTE: The county jails and the Department of Corrections need services for their residents. At Brainerd, Corrections is currently leasing a building and purchasing professional services and general and support services from the regional treatment center. Other regional centers may contract professional services to existing correctional programs.

b. Detoxification services.

c. Shared service arrangements with counties or private providers for other related chemical dependency services.

III. UTILIZATION

At the present time, some programs, such as the program for the hearing impaired at Moose Lake and the opiate addiction program at Willmar, attract clients from throughout the State. However, most clients come from within the region. If additional specialized programs are developed, this pattern may change.

Total beds needed: about 300 to 320 total state-wide Estimated annual admissions: 3,200 Estimated annual revenue: $12,000,000 Estimated average length of stay: 31-33 days

The regional centers are providing outpatient chemical dependency treatment to a small group of people.

It is anticipated that the current level of utilization will hold steady. Cyclical increases and decreases are likely to continue.

There may be some small expansion of out-patient services and shared service arrangements.

Consideration should be given to relocating Ah-Gwah-Ching's small program to Brainerd.

IV. STAFFING

Staffing is projected to remain at about the level currently delivering chemical dependency services.

V. PHYSICAL PLANT/LOCATION

In general, CD Programs are quite self-contained and use little other campus space.

The buildings are adequate and no major recapitalization is needed.

The location of the programs provides regional access.

MENTAL HEALTH

I. INTRODUCTION

The primary mission of the regional treatment centers is to provide inpatient psychiatric treatment to persons with major mental illness to:

Stabilize the individual and symptoms of illness which required t*he* hospital admission;

Improve functioning;

Strengthen family and community support;

Facilitate appropriate discharge, aftercare, and follow-up in the community.

The regional centers should serve persons:

whose illness is of such intensity or duration that community resources are not available;

with characteristics which reduce the likelihood of care in the community.

Services offered by the regional centers should be closely linked in structure and program with community based mental health services.

The mental health system is in a state of flux. The mental health initiative passed in 1987 requires counties to offer a full range of mental health services which should improve the alternatives to hospitalization.

In 1991, pre-admission screening will be required prior to hospitalization.

Recently both HCFA and JCAH have set higher standards for psychiatric hospitals which place greater emphasis on professional services and active psychiatric treatment.

II. SERVICES OFFERED

Services at the regional treatment centers will vary with the need for those services in the region served, but will include:

A. Inpatient Psychiatric Hospital Services:

1. Crisis stabilization and emergency services. This is ordinarily short-term care with the goal of assessing the person and providing short-term medical and psychiatric care.

2. Acute care, inpatient services. This is short-term treatment (less than 30 days) for persons with sudden onset of mental illness, serious deterioration of their mental health, or for persons who have serious, persistent mental illness and are suffering from an acute episode which requires short-term intensive intervention to stabilize the person, improve functioning, and facilitate referral, follow-up and placement.

3. Intense inpatient psychiatric programs. These are ordinarily of an extended duration (longer than 30 days) for persons with major mental illness. In-patient programs of this type are highly structured, providing therapy, a full range of activities, and close supervision. These people require an intense, high level of service.

B. Other Psychiatric Services:

1. Continued care for persons who have not stabilized or are not likely to stabilize to the point where transition to the community is clinically appropriate. Continued care is designed to rehabilitate persons over the long term and to prevent further deterioration.

2. Aftercare services to persons discharged from the regional treatment centers in order to facilitate clinical transition to the community.

3. Services for persons committed by the courts. Although such persons are ordinarily committed for inpatient psychiatric hospital care, some require treatment which requires a very high degree of supervision, but not psychiatric hospitalization. Thus, this group may receive the other services listed, but may also need other special services. The Intensive Treatment Program for Sexual Aggressives (ITPSA) at St. Peter is an example of specialized services.

4. Professional consultation with counties or community providers if purchased or developed as a shared service agreement with a county or other service provider.

III. UTILIZATION

It is estimated that the current rate of utilization will continue for the next few years and then slowly decline. Thus about 1,100-1,200 beds will be needed, the beds should be distributed into the various regions of the state. About 900 of these beds should be licensed as hospital beds. The other beds should be licensed as nursing home beds or supervised living beds.

There is sufficient need for beds in the area9 served by the current regional centers to justify operating the programs. However, some programs are small.

Some persons with mental illness currently being served at the regional centers in hospital beds do not need the level of care provided in a hospital. These are people with permanent mental impairment resulting from serious and persistent mental illness with a high level of need for nursing care or who cannot successfully adjust to placement in the community. For this group, humane, high quality care is the best alternative to prevent further deterioration of their condition. We estimate that 100-200 people may fall into this group. Careful screening of the individuals is necessary to determine if some hospital beds should be relicensed and staffed differently to better serve the treatment and program needs for these people. The State will continue to serve these peoples the license will be changed to reflect the services needed.

Some persons are committed to the commissioner as mentally ill and dangerous or as psychopathic personalities and require secure hospitalization. Minnesota Security Hospital will continue to serve this purpose. The Department is currently examining the need to increase its capacity to serve this group.

There is a need for more state-operated psychiatric hospital beds in the twin cities metropolitan area. Currently Moose Lake and Willmar serve many people from the metropolitan area.

IV. STAFFING:

The licensing and accreditation standards continue to evolve in the direction of higher level of staffing, higher skill level for staff, and more diversity of skill in order to provide active treatment to patients.

The Minnesota Security Hospital needs an increase in staff. This opinion is supported by a recent JCAH site visit. The patients are volatile, often in crisis, and suffer from serious psychiatric and psycho-social problems. The patients can be protected and treated in accord with contemporary standards only with an increase in staff. The current staff complement of 220 should be enhanced by 40 positions.

Anoka Metro Regional Treatment Center and Minnesota Security Hospital currently operate at or near 100 percent of capacity. This makes management difficult because:

state facilities cannot refuse committed patients; emergency admissions are frequently needed; persons with different needs or attributes affecting treatment may be inappropriately grouped.

V. CHILDREN AND ADOLESCENTS

In general, DHS does not support treating children or adolescents in the regional centers or in any institution. Children and adolescents should be served close to home to assure family involvement, avoid the stigma associated with being sent away to an institution, and to facilitate active county and school involvement. DHS fully supports the principles of permanency planning for children and does not favor long-term congregate care for children or adolescents. However, some small capacity for serving very troubled children with highly trained staff and intensive 24-hour care is necessary because of a lack of other options. Generally, these children have failed in many community programs operated for children and adolescents.

Current utilization

Willmar - 47 beds children, adolescents, ages 12-17
Brainerd - 44 beds children, adolescents, ages 8-17

Future admissions will ordinarily be limited to children age 12 and older.

These children and adolescents served at Willmar and Brainerd have the following characteristics:

a. Seriously emotionally disturbed children and adolescents unlikely to be safely maintained in community-based treatment settings.

b. Highly aggressive and dangerous adolescents including those who have committed heinous crimes and need treatment and/or correctional placement.

c. Repeated self-abusive and self-destructive children and adolescents.

d. Children and adolescents of borderline intellectual ability who exhibit behavior which poses a serious danger to selves or others.

e. Children and adolescents who are both emotionally disturbed and chemically abusive.

All children participate in a full education program, at the regional treatment center or in the local schools, depending on the severity of their disturbance and nature of their behavior problems.

At the present time, there is no other provider available in Minnesota offering comparable care to these children.

DHS does not intend to expand the availability of this service, believing that it should be strictly limited in size, and all children carefully screened prior to admission.

VI. PHYSICAL PLANT/LOCATION

Except at Minnesota Security Hospital, the physical plant is inadequate for providing treatment to the mentally ill according to contemporary standards.

Many buildings are not air-conditioned
Many buildings are more than one-story, not handicap accessible, and not designed well for those people who have trouble with ambulation, including persons receiving psychotropic medications.
Building design does not facilitate staff interaction with patients.
Building design does not facilitate use of space in accord with contemporary treatment standards.

The location of current beds does not accurately reflect the distribution of the population needing services. In relative terms, there are too few beds in the twin cities metropolitan area. There is some benefit to having regional treatment centers located throughout the state in order to facilitate coordination within a region and increase the likelihood of family involvement. However, each facility must be large enough to maintain an adequate level of professional staff. The cost of new construction must also be considered in deciding the appropriate number of sites.

The buildings at Anoka, Fergus Falls and Moose Lake are in the worst condition.

LONG TERM CARE FOR THE MENTALLY ILL AND ELDERLY

I. INTRODUCTION

The State plays a limited role in providing long term care to elderly mentally ill people and some people, ordinarily very elderly, who are medically fragile or clinically challenging. Rarely are these persons admitted directly from their family homes. Most are referred by a hospital or another nursing home. Few have any alternative to a state-operated nursing home.

The State currently operates nursing homes at Oak Terrace in Minnetonka and Ah-Gwah-Ching in Walker. Oak Terrace has a very old physical plant rented from Hennepin County. Because of the poor condition of the physical plant, the Department proposes vacating this facility by 1992.

The Department proposes expanding the number of sites where it provides this care by relocating beds to other regional treatment centers. A facility smaller than Oak Terrace should be located in the twin cities metropolitan area.

II. SERVICES OFFERED

A. Residential Care

The State should continue to provide residential care to the mentally ill and elderly persons who need nursing care and cannot be adequately served in the community because they:

a. are medically fragile or clinically challenging
b. exhibit severe or challenging behavior

Persons will be accepted for admission only after pre-admission screening by the counties. In general, placements occur where no community alternative is available and are expected to last longer than 180 days. Persons will be admitted who require staff-intensive, specialized services.

B. Technical Assistance

The State will expand its current capacity to provide technical assistance to community providers to handle the behavior problems of their patients, and will work with community providers to develop and facilitate community placements for younger persons who have heavy nursing needs and behavior problems. Technical assistance may include site visits, consultation with providers or provider training.

C. Auxiliary Services

The State may contract to provide other services needed in the region which build on the services provided by the regional nursing homes and are offered in conjunction with a community or community group. This may include meals-on-wheels or adult day care. The need for such services will vary by region, and will be developed in consultation with the counties served.

Some respite care will be offered if the care is funded by the family or other sources and if the individual meets the facility's admission criteria. Routine respite care for the elderly is more appropriately provided in the home community, but some specialized respite capacity may be needed.

III. UTILIZATION

The State currently has about 690 licensed nursing home beds. It is estimated that this number will be adequate for the next several years.

At the present time, about 500 beds are occupied. There are 260 people at Oak Terrace and 245 at Ah-Gwah-Ching. Current plans are to open 28 beds at Brainerd on January 1, 1989.

Because of the poor condition of the physical plant, admissions to Oak Terrace have been curtailed.

Some of the currently unoccupied but licensed bed capacity should be assigned to other regional centers for persons who are mentally ill but more appropriately placed in a bed licensed for nursing home care rather than in a bed licensed for hospital care.

Relocation of persons must be carefully planned and should attempt to accommodate any remaining ties to family or community. Relocation will take into account personal choices and follow the Department's rule governing relocation.

There is no anticipated need to expand the number of licensed nursing home beds operated by the State. Although the State's population is aging and changes in federal regulations may increase the number of people meeting the admission criteria, the increased development of alternative care grants and the case mix method of reimbursement to nursing home providers should increase the availability of beds in the community which can serve those people.

IV. STAFFING

Some increase in staff at Ah-Gwah-Ching may be needed to provide active treatment to the nursing home residents who are mentally ill. This could be accomplished by retaining

the current staff level and relocating a small number of licensed beds.

Oak Terrace staff may be employed at a new metropolitan location or other regional centers.

V. PHYSICAL PLANT/LOCATION

The current facility at Oak Terrace is leased from Hennepin County and will require expensive renovation if it is to continue to serve patients. It is recommended that Oak Terrace be closed by 1992 and that the licensed beds at Oak Terrace be redistributed to other facilities operated by DHS. Nursing home capacity of 60-100 beds should remain in the metropolitan Twin Cities area.

Small long-term care units may be operated at other regional centers if the screening of patients currently occupying hospital beds supports that change. Some Oak Terrace residents could be moved to these units.

Distributing the nursing home beds to other regional centers will offer greater regional access.

DEVELOPMENTAL DISABILITIES

I. INTRODUCTION

All persons with mental retardation or related conditions can be served in the community. Services can be developed to meet their individual needs, by building on community resources, developing in-home support services, and establishing stable and consistent residential care. Even persons with intense or complex needs can be served in small homes in the community and in training and habilitation services which are community-based.

In the last few years, DHS has run pilot projects to test state-operated community services for persons with developmental disabilities, both residential services and training and habilitation services. DHS has successfully used Medicaid funds to develop community placements for some of the most medically fragile persons and persons with challenging behavior.

The population remaining in the regional centers is steadily dropping at the rate of 150-200 year, to 1,494 for June, 1988. For the past year and a half, the regional centers have not been licensed to serve children. It is time to identify the needed resources and plan for the placement of the remaining persons into small, community-based home9.

There is a role for the State in the delivery of services to persons with developmental disabilities. The State should focus on providing care to those people who are most difficult to serve, and its capacity to serve should be maintained at a level sufficient to offer back-up in the various regions of the State. This will assure the stability of care government can offer, and provide an appropriate alternative for the people served, their families, and the State as a purchaser of service. It will also assure that services are available when other community services fail, or when medical or behavioral problems require intense, specialized care.

The Department proposes to eliminate large state-operated congregate care in the regional treatment centers by June 30, 1993, and to facilitate the movement of all remaining persons into community homes. About one-third of the group remaining would be served in state-operated homes for six people or less. The balance would be placed in other residences.

II. STATE OPERATED REGIONAL SERVICES

The State will continue to provide direct service to people with developmental disabilities.

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A. Community-Based Residential Services;

Long-term residential care located off campus in small residences serving four to six persons in the community. The location of the homes will be determined by:

Personal preferences of persons served and their families;

Appropriate grouping of persons served;

Proximity to necessary community support services;

Need for state-operated services in the region;

Availability of qualified staff.

DHS will provide residential care directly to about one-third of the persons remaining in the regional treatment centers. It will target the persons most difficult to serve, including those with severe medical, mobility and/or behavior problems.

The psychiatric units in the regional centers will provide services to persons with developmental disabilities who require inpatient psychiatric treatment, but with the goal of stabilizing the person to the point where he or she can return to a community placement.

B. Crisis Intervention:

Two types would be offered by state employees.

1. Outreach services: Provide assistance to person's provider and/or family at place where person ordinarily resides or works.

2. Short-term back-up residential services using beds licensed for adult foster care.

Counties would contract for the service (MA payment).

Specially trained staff would be available for medical or behavioral crisis.

C. Technical Assistance:

Training or professional consultation offered to counties, community providers, including state-operated community providers, and families.

Counties or providers would be encouraged to purchase time in large quantities on an annual basis to permit budgeting and planning.

Initial training, continued training and specialized training would be offered.

Specialists would be located in regional offices to work with the county case managers, facilitate service development in the region, and work with providers and families.

One of the objectives for this group would be to incorporate family members and community residents into the planning and implementation of services.

This service could include respite care, not to exceed 30 days/year, either in a person's home or in beds licensed for adult foster care.

D. Training and Habilitation Services:

Ordinarily, the State should rely on community providers to develop training and habilitation services for all persons who need that service. However, there are persons who present special needs, and there will be a heavy demand for services created by complete deinstitutionalization. The current day programming system is not able to handle that demand. Also, private providers are requesting very high rates to serve difficult clients.

Some of the most innovative training and habilitation services are being developed by the regional centers' staff. The State will continue to develop programs which will highlight community participation and integration, and be targeted to the persons most difficult to serve.

The State proposes to operate services for about 550 people, providing services of two types.

1. Community-based employment units.

2. Community-based day program units

The administration of these services will be entirely separated from the residential programs.

Persons' eligibility for these services will be independent of their place of residence.

III. CENTRAL OFFICE SERVICES SUPPORTING COUNTY AND REGIONAL EFFORT

Approximately two-thirds of the persons discharged from the regional centers by July 1, 1993 will need community placements (not state-operated). The Department will provide resources to facilitate the placement of these people by working with the people affected, their families and the counties to plan and develop services.

A. Background:

Four thousand eight hundred (4,800) persons are now served in 337 ICFs/MR (2,400 persons served in facilities having 16 beds or less).

Over 200 people have moved from regional centers to the community in the past year.

About 950 persons with mental retardation or related conditions live in nursing homes. Under an agreement with the federal government, about 350 of these people must be relocated in the next year and a half.

Five thousand three hundred and forty-six (5,346) persons are served in day training and habilitation services.

One thousand fifty-seven (1,057) people are receiving SILS (semi-independent living services).

Three hundred seventy-four (374) families receive subsidies to continue care at home.

About 1,600 people are in "waivered services".

The average county case management ratio is about 1:65 (county case managers: persons with mental retardation or developmental disabilities).

Training in Fiscal Year 1988:

Training series for 366 case managers over nine months.

Additional training on serving persons with special needs.

Training to 3,000 people concerning Rule 40 (use of aversive and deprivation procedures in behavior management).

Three hundred fifty (350) ICF/MR beds were closed in the past year and people placed in alternatives.

Conclusion: In addition to the RTC discharges, counties must plan to move 360 people currently in nursing homes and 240 people currently in ICFs/MR (to open spaces for RTC discharges). There may also be ICF/MR closures. Thus, this plan calls for moving 2,000 or more people from now through June 30, 1993.

B. Plan To Relocate Current Regional Center Residents:

		Number of Persons
Year 1	(7/1/89 - 6/30/90)	180
Year 2	(7/1/90 - 6/30/91)	230
Year 3	(7/1/91 - 6/30/92)	340
Year 4	(7/1/92 - 6/30/93)	150
		900

From RTC to:

Existing Waiver - 120
Upgrade ICFs/MR - 240 beds -- (move 240 people out to existing waiver)
New ICFs/MR - 180 beds
Targeted Waiver - 360 -- (Special waiver from HCFA just to move persons in RTCs)

Benefits:

Uses existing waiver Promotes diversified funding Upgrades existing ICFs/MR

Moves 240 people (in addition to persons leaving RTCs) to more appropriate services

C. Components to the Plan:

1. In-home support services: (SILS/Family Subsidies)

In order to accomplish reduction at the regional centers, appropriately place nursing home residents, and meet needs of new people entering the system, SILS and Family Subsidies must be increased.

2. Increased County Resources:

Increased technical support from DHS

More case managers

More planners, resource developers and recruiters during the transition

More support staff for billing, clerical, contract management and audits

More county licensors for foster care and SILS providers

Possible Sources:

Medical assistance

Re-deploy state staff to counties

Increase funding for case management

Simplify case management

Develop regional state-funded services

Administration dollars from the waiver

Increase coordination with technical institutes and community colleges; supported by U of M Affiliated Program and Governor's Planning Council on Developmental Disabilities

Develop manuals at DHS Develop training

materials at DHS 3. Increased DHS Needs;

Additional staff for: Licensing

County "need determination" and technical assistance during ICF/MR development

ICF/MR and day training rate setting, audits, and appeals

Case management appeals

Day program specialists

Waiver administration and technical assistance regarding waiver

Central office coordination of training and technical assistance

Upgrading information management - hardware, software and personnel

Transition planning

Increased quality assurance efforts

Employee assistance

IV. STAFFING

Many current staff will be needed to staff the new state-operated services including:

residential care
training and habilitation
technical assistance
crisis intervention
staff training
licensing
support staff
accounting, auditing, financial management
quality assurance
planning and coordination

Some staff will be needed to enrich programming for persons with mental illness.

Alternative uses will create demand for staff.

Relocation of Oak Terrace beds may create positions on other campuses.

Other options are under discussion including early retirement, retraining and enhanced severance.

Assistance should be offered to employees affected by the changes.

V. PHYSICAL/PLANT LOCATION

The Department of Human Services will not need the buildings at Cambridge and Faribault once residential and day services are moved off the campuses. Alternatives for the physical plant will be actively pursued. The community colleges, technical institutes, Department of Corrections and others need space.

Some space will also be vacated at Brainerd, Fergus Falls, Moose Lake, St. Peter and Willmar.

The Department will work with the affected communities to mitigate the effect of the change.

New services will be developed and some may be located in the communities where there are regional centers. Also, regional offices will be needed to provide support to the new services.

There are several possible options to explore for capitalizing the new state-operated residential services.

DHS Proposal 7/28/88

CHEMICAL DEPENDENCY

I. Services offered

A. Primary and extended residential care
B. Follow-up care to persons discharged
C. Out-patient programs on campus
D. Services under contract or through shared services agreements

1. Department of Corrections
2. Detoxification
3. Other services for which the RTC can compete in the region

II. Utilization

Effects of Rule 25 and Consolidated Chemical Dependency Treatment Fund caused decrease in utilization
Projected stability
Need is estimated to continue at the current level of about 300 - 320 beds
Most programs draw clients from their own region; some programs
draw state-wide.
There may be some small expansion off-campus through shared service agreements.

III. Staffing

Remain at about the level currently delivering chemical dependency services

IV. Physical Plant/Location

Physical plant is adequate
No major recapitalization is needed
Regional distribution should continue

DHS PROPOSAL
CONFIGURATION

JULY 28, 1988

Campus	Recommendation	Service Options	Alternative Uses	Critical Issues
Ah-Gwah-Ching	.service to the elderly; relocation of chemical dependency program to Brainerd	.service to the elderly; retention of chemical dependency program		
		.expansion of technical assistance and outreach		
Anoka	.service to the mentally ill and chemically dependent in a new metropolitan psychiatric hospital	.extended care capacity for service to elderly		.need for a new physical plant .location
Brainerd	.service to the mentally ill, chemically dependent and elderly			
	.service to developmentally disabled through SOCS			.capital, feasible management structure
	.day habilitation and training services			
	.expand nursing home			.renovation, appropriate
		.regional support services		

Campus	Recommendation	Service Options	Alternative Uses	Critical Issues	
Cambridge/ Faribault	.stop providing services to developmentally disabled in large congregate settings				
	.continued service to the developmentally disabled through SOCS			.capital, feasible management structure	
	.day habilitation and training services				
		.regional support offices			
			.nursing home		
			.commercial activities		
			laundry		
			motor vehicle repair and maintenance		
			.adaptive technologies		.capital
			.community/state educational system		
			.housing		
			.corrections system		

Campus	Recommendation	Service Options	Alternative Uses	Critical Issues
St. Peter	.service to the mentally ill and chemically dependent			
	.service to the developmentally disabled through SOCS			.capital, feasible management structure
	.day habilitation and training services			
		.regional support services		
Willmar	.service to the mentally ill and chemically dependent			
	.service to the developmentally disabled through SOCS			.capital, feasible management structure
	.day habilitation and training services			
		.regional support services		